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ACT and CBT in Older Age

Towards a Wise Synthesis

David Gillanders and Ken Laidlaw

Abstract

In this chapter we review the application of a new form of cognitive-behavioral therapy (CBT), acceptance and commitment therapy (ACT), and consider its use with older people. We provide an overview of ACT as distinct from CBT, and review the potential utility of this therapy for the types of presentations of distress in later life. As ACT is relatively new there is a somewhat limited evidence base for its use with older people. We anticipate this will develop as there is a need for efficacious psychological therapy treatment alternatives with older people. As older people can face age-related challenges that may require a response different from that advocated in traditional CBT approaches, we are of the opinion that ACT possesses significant potential for use with current and future cohorts of older people. The evidence for ACT's efficacy is critically evaluated here and the application of evidence for use with older people is reviewed and discussed.

Keywords: acceptance and commitment therapy; cognitive-behavioural therapy; late-life depression; older people; geropsychology; gerontology; ageing.

Introduction

Despite prevalent negative age stereotypes (Cuddy, Norton, and Fiske 2005), ageing is *not* an inevitably negative experience (Carstensen et al. 2011). In a longitudinal survey, older people report better emotional stability and are more competent at emotional regulation in comparison to adults of working age (Carstensen et al. 2011). The current cohort of older

people experiences a more positive quality of life than previous ageing cohorts (Rohr and Lang 2009), with ageing well entailing an individual becoming active in shaping and responding to their environment. This may be especially important in the complex and dynamic social context of ageing (Rohr and Lang 2009). Ageing can be a time of continued growth, mastery, and feelings of accomplishment, connection with others, and of leaving a legacy for future generations (Scheibe and Carstensen 2010). Research evidence suggests that ageing can result in an enriched positive emotional trajectory of development. Emotion-regulation skill translates into older people being more resilient than younger adults (Gooding et al. 2012). As older people become aware of their finite lifespan, they are motivated to foster better emotional relationships and enhanced affect regulation in the moment (Scheibe and Carstensen 2010). This is a point not lost on others in the field, with Knight (2004) observing:

The more traditional, largely pessimistic, view has been that adult development and increased experience make people rigid and set in their ways. Yet some clinicians working with the elderly have felt that the effect is quite the reverse: that growth and experience teaches adults to be more flexible, less dogmatic, and more aware that there are different ways of looking at life.

(Knight 2004: 46)

If this view is accepted as reflective of the ‘normal’ experience of ageing, then older people may make better candidates for psychological therapy (Laidlaw 2013a).

The ‘ageing paradox’ exists to challenge a model of ageing solely in terms of loss and deficit, although it is also acknowledged that age can bring with it many challenges at an individual level. The ageing paradox is that whilst resources may diminish and threats may increase with age, empirical studies show well-being and life satisfaction (for the majority) are surprisingly high and remain so until the last stages of life (Westerhof, Dittmann-Kohli, and Bode 2003). The ageing paradox is understood to involve successful adaptation, redefinition of

values and goals, engaging in new behaviours and seeking out new resources, and a lowering or changing of aspirations (Dittmann-Kohli 2005).

Subjective well-being also remains relatively stable and invariant to age, but less stable when physical health is compromised (Kunzmann et al. 2000). However even in these circumstances, reductions in positive affect are balanced by negative affect remaining stable (Kunzmann et al. 2000). Therefore, well-being in later life appears to be subjective and dependent upon one's frame of reference. George (2010) suggests older people make more 'downward social comparisons' in that they compare themselves with others they perceive to be less fortunate than themselves, and hence well-being remains relatively stable even during times of loss, transition, and change. Ageing, however, is more of a process than a state and as such is complex and multifactorial with Diehl and Werner-Wahl (2010) proposing that awareness of age-related change (AARC) may capture the personal multidimensional experience of ageing. An individual's idiosyncratic awareness of aging results in a perception that life has changed, and attributions about the nature of that change are due to some consequence of ageing, or of the passing of time. Changes attributed to age are therefore perceived as either positive or negative. This integrative model acknowledges that awareness of age-related change may serve an important motivational factor in terms of an individual lifespan developmental trajectory. Perception of increased vulnerability may serve to trigger the use of self-regulation strategies and as such may moderate effects of loss deficits associated with ageing. The AARC model therefore places a central role for psychological processing of the experience of ageing, with cognitive, affective, and behavioural responses predicated upon the apprehension and appraisal of the individual.

Growing older can nevertheless be associated with acute and chronic physical illnesses, comorbid conditions such as depression and anxiety, or subclinical depression/chronic dysthymia. Medical conditions increase rates of depression in later life, with a greater burden of

illness resulting in an increased risk of depression, but most older people who develop physical problems do not develop depression. In a systematic review of community-based studies assessing prevalence of late-life depression, Beekman et al., (1999) calculated an average prevalence rate of 13.5% for clinically relevant depression symptoms. More recently, McDougall et al. (2007) reporting findings from a large epidemiological study looking at the prevalence of depression in people aged 65 years and older from across England and Wales, estimated prevalence of depression among older people to be 8.7%, with a prevalence rate for severe depression of 2.7%. McDougall et al. (2007) report no association between age and prevalence of depression. Factors more associated with depression were being female, medical comorbidity and disability, and social deprivation. These factors are more universally present than related to age challenges. Anxiety disorders are more common than depressive conditions, with Generalized Anxiety Disorder (GAD) and specific phobias being the most common sources of emotional distress in later life, and anxiety symptoms being more common still (Worlitzky-Taylor et al. 2010).

Blazer (2010) notes that depression rates in later life are lower than most professionals expect and that this may be because of three protective factors in later life. First is that older people have an appreciation of having lived longer than they have left to live and therefore tend to prioritize goals that are more meaningful in the present. As such, they tend selectively to optimize the positive aspects of the present. Indeed, research indicates nondepressed older people have a positivity bias for recall of memories (Carstensen and Mickels 2005), so Blazer (2010) may have a point here. The second factor is wisdom, with research suggesting age itself is irrelevant to the development of wisdom; rather, dealing with ambiguity and adversity develops greater wisdom, and as older people have an abundance of life experience they have more opportunities to develop competence in this domain. With longitudinal studies evidencing richer emotional development in later life (Carstensen et al. 2011), Blazer again seems to have

an interesting explanation for the low rate of distress in later life. The third protective factor is that people adapt and accept events in later life partly because of the first two factors, but also because events such as the loss of a spouse are not unanticipated; these are events that are ‘on time’ and as such older people accept them as part of life. This is an interesting idea and it seems intuitively right and consistent with clinical practice as many older patients talk of having thought in advance of what they would do if their spouse were to die before them. It is an education for younger therapists to see older men and women learning to live alone, often for the first time in their adult lives, especially after marriages lasting close to fifty years and sometimes more.

The needs of older people with mental health problems such as depression and anxiety remain under-recognized and inadequately met, with access to psychological therapy frequently being insufficiently supported and available (Laidlaw 2013a). Despite anxiety symptoms and disorders being risk factors for disability and death (Bryant, Jackson, and Ames 2008) anxiety remains under-treated, tending to go ‘under the radar’ of mental health professionals and older people themselves, perhaps because of the presumed ‘common currency’ of the universal experience of anxiety and stress symptoms (Laidlaw 2013a). Older people may experience social isolation, withdrawing from others due to their own and other’s stigmatization and stereotyping of older people. Furthermore, older people may fear further illness or deterioration of existing conditions. They may experience a range of cognitive difficulties with attention, concentration, judgement, inhibition of behaviour, and memory problems. Old age can be a time of multiple losses in terms of physical and mental functioning, valued roles, and bereavements.

Individuals with long histories of poor health or mental well-being are likely to carry these lifelong struggles into their third and fourth age and will likely be at greater risk of developing further later-life-related problems due to impoverished social support, poorly developed coping responses, and multiple comorbidities. People with chronic histories of

depression are likely to get an especially poor deal from mental health services and are at risk of becoming ‘revolving door’ patients, referred in and out of services (McCullough 2012). Older people, in particular female spouses, may have significant burdens of caring for others with physical health needs, dementias, and mental health problems (Pinquart and Sörensen 2011). In summary, later life, in common with other stages of adulthood, can bring with it significant struggles, burdens, and threats to well-being. Psychological therapies exist that have been shown to be useful to older people in managing these challenges. Cognitive-behavioural therapy (CBT) is one such intervention that has a strong evidence base in addressing the needs and issues frequently faced by older people (Laidlaw et al. 2003; Pinquart, Duberstein, and Lyness 2007).

Characteristics of CBT for Older People

Several of the structural features of CBT make it especially well suited to address the psychological issues frequently seen in later life. CBT is highly structured, involving planning, agenda setting, and both in-session and between-session goals. There is an emphasis on therapist and client developing a shared understanding of the client’s problems and the meaning of these in the client’s phenomenological world. CBT therapists seek to achieve this via a highly collaborative relationship, where both parties view themselves as working together as a team to help the client. The combination of collaborative relationship and shared understanding of the client’s problems, and in particular the here and now factors that maintain them, are particularly helpful in ‘remoralizing’ the client. Problems that were previously experienced as hopeless, isolating, and inevitable can become understandable, shared, and solvable.

CBT is explicit in sharing a formulation or case conceptualization with the client, at a level of detail that is accessible and meaningful to them. The joint development of a collaborative case conceptualization is part of the process of relationship building, socializing the client into the cognitive model, and developing shared understanding. The case formulation

also helps the therapist to guide and plan treatment, from strategies to specific tasks and interventions. The formulation helps the therapist to anticipate the client's likely responses to interventions and can help to reduce roadblocks and resistance. Laidlaw et al. (Laidlaw, Thompson, and Gallagher-Thompson 2004) developed a comprehensive case conceptualization framework (CCF) that can accommodate the broader age context when working with older people.

In terms of specific interventions, CBT for older people draws heavily on cognitive *and* behavioural aspects of treatment. Behaviour activation/activity scheduling is useful when an older person has stopped doing things that would previously have been a source of positive reinforcement. Often this strategy is supplemented with asking the client to rate activities for the degree to which they bring a sense of pleasure or achievement. Such ratings can be helpful in refuting a depressed client's typically pervasive pessimism regarding the point of setting goals. In addition, older people who have stopped doing certain activities may find their resumption associated with fear, or loss of confidence, particularly fear of falling or injury. Behavioural tools such as collaboratively constructed graded exposure hierarchies can be useful ways of approaching such behaviour change.

While these tools derive primarily from the behavioural approach, within CBT their use is also designed to potentiate cognitive change. Just as the rating of a planned activity for pleasure or mastery can bring a powerful behavioural refutation of pessimistic appraisals, so can progressing through a gradually increasing fear hierarchy lead to changes in appraisal of the self as capable and the world as less threatening. Such exposure sessions can be delivered either with or without emotion-regulation strategies, such as breathing relaxation. Diverse relaxation strategies, such as Applied Relaxation (Öst 1987) or guided imagery (Arena and Blanchard 1996) can also be used to help clients who experience persistent over-arousal to reduce the physiological sensations and emotions associated with this.

Finally, the shared construction of meaning and narrative, and the development of explicit strategies for managing and responding to negative thinking, facilitates the problem changing from unknowable and inevitable to understandable and potentially changeable. Examples include using automatic thought records to ‘catch’ thoughts and to modify these to be more realistic, less catastrophic, and less pessimistic. Over time, therapist and client will detect recurring themes in such work and will explore and modify the underlying beliefs that ‘support’ or drive problematic responding, such as ‘Being old means that I am redundant and no use to my family.’ Such techniques are effective in helping older people to regain control over their behaviour, emotions, and their thinking and by doing so, break the maladaptive patterns that maintain problems.

CBT is applicable when circumstances facing individuals have no easy solution such as when physical health problems are likely to be long-standing and may even be degenerative. As CBT with older people is still developing an evidence base when dealing with situations of a more chronic and complex presentation in longer-term conditions, this can be very challenging for therapists. A particularly acute challenge for novice CBT practitioners is where individual appraisals are seemingly relatively realistic, or where cure or remission of a problem is unlikely. A fundamental misapprehension of the applicability and utility of CBT with older people is that CBT will be less effective when negative thoughts are associated with ‘realistic’ challenges. Of central importance in using CBT in these conditions is the concept that it is the individual’s appraisal of their experience rather than the experience itself that is important in understanding how well they cope with an event. As famously put by the Stoic Epictetus, ‘People are not disturbed by things, but by the view they take of them.’ A more modern CBT maxim may be, ‘It’s not what happens to you, but how you react to it that matters.’ Thus cognitive restructuring and behavioural modification retain important utility when older people are confronted with age-related challenges. Evidence consistent with this point is clinical trials showing good outcomes

for CBT when applied to people with depression and anxiety in Parkinson's disease (Dobkin et al. 2011), the utility of an augmented approach to CBT for post-stroke depression (Broomfield et al. 2011), and the potential applicability of CBT to people with dementia (Wilkins, Kiosses, and Raudin 2010).

However, when a person has experience of using cognitive strategies and these have not worked, or when the client's pursuit of emotional, physiological, or cognitive control results in them avoiding important parts of their life, a possible psychological therapy alternative to more traditional forms of CBT is acceptance and commitment therapy (ACT, said as one word, not three letters). A particularly useful strategy in helping people to manage age-specific challenges is a focus on 'experiential avoidance', and this is at the heart of ACT (Hayes, Strosahl, and Wilson 2012). ACT may therefore become part of a range of efficacious therapeutic alternatives available to older people. This is an important aim as it will seldom be the case that any single format of psychological therapy will work in all circumstances and with all populations. Hence we welcome the entry of ACT as a new opportunity to increase access to psychological therapy for older people.

ACT is part of the cognitive and behavioural therapies. It is distinct from cognitive therapy in placing less emphasis on cognitive change or cognitive mediation of psychological disorders. ACT is part of behaviour analysis and draws its historical roots from the radical behaviourism of B. F. Skinner (e.g. Skinner 1974). In radical behaviourism, all psychological events including thoughts, urges, sensations, and feelings are viewed as forms of behaviour. The goal of such a stance is to construct an applied behaviour analysis of such 'private events' and their influence on overt behaviours, within specified contexts, with the same kind of rigour and precision that behaviour analysis has traditionally brought to overt behaviour.

The empirical literature for ACT shows promise (e.g. Hayes et al. 2006; Hayes et al. 2010; Ruiz 2010; Powers et al. 2009). There are now over seventy trials of ACT, of which many

are randomized controlled trials, across a very wide range of clinical and subclinical problems. ACT interventions have been used successfully to treat psychiatric disorders such as major depression, generalized anxiety, psychosis, eating disorders, and substance misuse problems. In the physical health arena, ACT interventions have been used successfully with people with diabetes, epilepsy, obesity, and for smoking cessation. When compared to waiting list controls and to treatment as usual, ACT interventions typically show large effect sizes. In comparison to well-established psychological interventions such as cognitive therapy, the picture is more controversial. While a number of meta-analyses have found that ACT interventions show a modest effect size *in favour* of ACT, these trials have been criticized as being of methodologically poorer quality on a range of factors that *could* lead to inflated effect sizes (e.g. Öst 2008).

There have been robust responses to such critiques (e.g. Gaudiano 2009), suggesting that the Öst analysis is unfair as it fails to take account of the level of funding received by the ACT trials and the stage of development of the ACT work in comparison to cognitive therapy. The state of the empirical evidence is further reviewed by Powers et al. (2009), who, while also finding a large effect comparing ACT to waiting lists or to treatment as usual, find no difference between ACT and established treatments in terms of outcome. The picture is made more complicated, however, by Levin and Hayes (2009), who argue that Powers et al.'s meta-analysis was incorrect, having labelled some measures as primary outcomes when in fact they were secondary, and vice versa. In addition, they suggest that Powers et al.'s grouping of treatments in the treatment as usual group puts active well-established treatments in that group, inflating the effect size for that comparison. When Levin and Hayes (2009) correct these 'errors', they find that the effect size for ACT in comparison to active treatments favours ACT. Finally, at least one early ACT study (Bach and Hayes 2002) was included in a critical review of reporting practices

(Cook et al. 2002), suggesting that the reporting of trials could be improved and that the results of such trials should be treated with caution.

It is of note that in the US, the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (www.samhsa.gov) has recently entered ACT into its National Registry of Evidence Based Programmes and Practices (SAMHSA 2010). In addition, in the field of major depression, ACT has been designated by the American Psychological Association as a ‘probably efficacious treatment’ (APA 2011). The APA also describe ACT for Chronic Pain as having ‘Strong Research Support’ (APA, 2011). Further, more recent randomized controlled trials, directly comparing ACT and CBT, have shown that these treatments appear equally effective and credible, certainly in the anxiety and depressive disorders (Arch et al. 2012; Forman et al. 2007; 2012).

A balanced perspective suggests that the ACT literature shows promise as an intervention, but that the work is continuing to mature and that future clinical studies of ACT could benefit from the methodological recommendations set out by earlier critical reviews. What is particularly notable is the wide range of mental and physical health problems to which the same functional technology has been applied. In addition, much ACT work has focused on disorders that are notably hard to treat due to chronicity. Whether ACT is superior to other well-established treatments is perhaps less important than finding that ACT appears *at least* as effective as other active psychological treatments, giving therapists an alternate choice of intervention, particularly under circumstances when cognitively oriented or control-based interventions have been tried and found to be insufficient.

An ACT Approach to the Problems of Older People

An ACT approach is at its heart a *functional contextual* behavioural approach. While in CBT we might emphasize the meaning structures and understandings that older people make as they age

and encounter life's challenges, in ACT the focus is upon what the older person *does* in a specific context. ACT further specifies six overlapping behavioural processes that help a therapist to conceptualize the functions of a person's behaviour. These six processes can be represented in a hexagonal diagram sometimes called the 'ACT Hexaflex' ([Figure 1](#)). The ACT Hexaflex model describes six overlapping and interdependent processes that lead to either psychological inflexibility or psychological flexibility. In [Figure 1](#), the hexagon on the left represents the inflexibility processes, whilst the one on the right represents the other side of the same coin: the six psychological flexibility processes.

Briefly, the six inflexibility processes are: experiential avoidance (efforts to avoid private events such as feelings, memories, and thoughts); cognitive fusion (taking thoughts literally, being excessively entangled in thinking, behaviour being dominated by cognition); lack of contact with the present moment (worrying about the future or brooding on the past); attachment to a narrowly defined conceptualized self (being dominated by a narrow vision of who we are and what is possible); lack of contact or clarity of values (not being in touch with what is important to us, being guided instead by 'oughts, shoulds'. etc.); and lack of committed action (inactivity, impulsivity, or acting to avoid difficult experiences). When combinations of these six processes are in operation, behaviour is relatively more rigid, inflexible, and oriented towards threat and avoidance.

[INSERT FIGURE 1 HERE]

The six processes of psychological flexibility are: willingness (choosing to take in whatever life is offering, both in the world outside and in the world of private events); defusion (stepping back from the dominance of cognitive events over behaviour, seeing thoughts as thoughts); present-moment awareness (being in touch with now, as each moment unfolds); a repertoire of flexible perspective-taking skills known as 'self as context' (e.g. seeing the self as the context in which psychological events happen, or as an observer of psychological content,

rather than identifying with that content); values (knowing and connecting with what matters most to us); and committed action (taking steps and making commitments to behaviours that lead us in the direction of our values). When combinations of these six processes are active, a person has greater capacity to be present to what is happening now and, given what the situation affords, to choose to persist or change behaviour in the service of their own overarching life goals or values.

Using this model we can begin to develop functional analyses of the kinds of problems faced by some people as they age. Increasing physical health problems, for example, may lead to activity limitations, which in turn makes it hard for a person to maintain committed actions to things that they value, such as providing childcare for their grandchildren. In this context, the degree to which a person is ‘fused’ or ‘entangled’ with thoughts that equate this caring role to their worth as a person will predict the degree of psychological flexibility they have to persist or change behaviour in the service of their values. In CBT we might explore the meaning of being a carer and use strategies to institute more balanced thinking, for instance seeing a caring role as only one element of self-worth. In an ACT model, by contrast, we would focus less effort on changing the meaning of such self-statements, preferring instead to use strategies that encourage seeing thoughts and beliefs as mental events only and instituting valued behaviour even in the presence of negative thinking.

The ACT therapist may use mindfulness techniques as part of such ‘stepping back’ from thinking and establishing direct control over behaviour, while letting go of the need to control thoughts, feelings, and physiological sensations. Further ‘defusion’ exercises include visualizing what a difficult thought or feeling would ‘look like’ if it could be seen in the room (Hayes et al. 2012). In using these kinds of intervention, therapists negotiate moment by moment what the client is willing to experience and what they are not, thereby creating a therapeutic context in which acceptance/willingness is fostered. Levy (2003, 2009) suggests that awareness of ageing

may not always be a positively welcome experience, as negative stereotypes of ageing may make people fearful of growing older. Ageist societal attitudes internalized from a very young age and reinforced throughout adulthood can become negative age stereotypes reinforced by an attentional bias towards negative information about ageing (Levy 2003). ACT may be useful when working with an older person's future fears. In this context thoughts and feelings are examined not for their truth value but for the degree to which they are useful guides to behaviour. By examining the functional consequences of doing as thoughts suggest, their power to control behavioural responding is reduced.

One element that ACT emphasizes in this shared examination is an analysis of the 'workability' of currently employed strategies for dealing with whatever problem a person is seeking help for. In this early phase of ACT work, the client is typically struck by the discovery that much of their behaviour is in the service of reducing, controlling, or avoiding the problem (be that difficult thoughts, feelings, or physiological sensations). It is also usually evident that many of these avoidance-based strategies are maintained *precisely because* they provide short-term relief or reduction of discomfort, but that in the long term they do not help the client to live a full, vital, purposeful, meaningful life.

The older person who has experienced a fall, for example, becomes entangled with anxious thoughts and feelings regarding leaving the house, likely more so when the weather is icy. Their deciding not to go out temporarily reduces their anxiety about going out and gives a brief respite from the 'what if I fall?' thinking. In ACT, we might help the person to make deep experiential contact with the things they would leave the house for. Using eyes-closed exercises, a therapist might help the person to contact images and memories of a valued social contact, or a family event. Using imagery and metaphor the therapist works with the client to develop willingness to experience anxiety and anxious thoughts, in the service of taking specific steps in the direction of these valued life goals.

The explicit focus on values in ACT is a part of the model that is currently poorly developed in relation to issues of ageing considered by other psychological therapies. Consistent with evidence from socio-emotional selectivity theory (SST; Carstensen, Isaacowitz, and Charles 1999; Scheibe and Carstensen 2010), a person's values change as they age. Values of work and productivity may become de-emphasized, while those of community and connection may remain high. Additionally, some values (such as family) may remain important, though the specific steps and goals that make up this valued direction are likely to change in older age. The value of being a parent at the age of 75 is likely to involve different specific behaviours than the same value at the age of 30. This is, of course, not specific to old age: a person who has valued being a parent will have changed the specific ways in which they live this value many times over many years. The behaviours involved in parenting a six-month-old baby are different from those needed when a child is 3 or 10 or 17. Importantly, these ideas are theorized and more research is needed examining how values and their associated committed actions change and develop in response to ageing and age-related challenges. One study that does provide a preliminary investigation of these issues is described by Ferrell et al. (2010). In this study, a group of older adults and college students were compared on their responses to measures of values, well-being, and life satisfaction. After writing their own ideographic values of how they would most like to be in relationships (friendships, family, and romantic relationships), participants rated their agreement with statements related to their own self-reported behavioural commitment to living in accordance with that value: e.g. 'I am committed to living this value and acting consistently towards this value'). Commitment to values was associated with greater well-being and life satisfaction for both age groups. Interestingly, there was no difference between the younger and older adults in their commitment to values. In addition, life satisfaction was higher in the older adult group.

An element of the ACT model that may be particularly useful to therapists working with older people is the ‘attachment to the self story’. This might be useful on several levels. First, given the cultural context in which most therapists in the Western world have grown up, we are highly likely to have been exposed to age-related stereotypes. The attachment to the self-story may be a particular form of age-related stereotype that may become a trap for therapists. While it is true that clients in psychological therapy may well be ‘wed’ to the story of themselves (e.g. ‘I cannot form good relationships because of my childhood’), there is no evidence that older people are any more or less vulnerable to this process than younger adults. The belief that ‘older people’s psychology is more rigid and less amenable to change’ may be exactly the kind of attachment to a story that could work against therapists and health professionals. Laidlaw (2010, 2013b) has pointed out that a potential therapeutic gap exists when CBT therapists do not make use of the individual’s life-story information. In short, we need to figure out how to use the life experience of older people yet retain the here and now orientation of cognitive-behavioural therapies so the person can use this new information to help themselves address their current problems in a more personally empowered way. Laidlaw (2010, 2013b) suggests the use of timelines, and the use of life experience to help people reframe their self-story as one of resilience and survival enhancing compassionate self-acceptance in a move consistent with ACT philosophy and values.

Of course, the other level at which this element of the ACT model may be useful to therapists working with older people is that older people (just as younger people) *may well be* fused with such stories about themselves! Indeed, evidence suggests that older people’s own negative attitudes to ageing are associated with poorer outcomes in relation to mental health and quality of life (Kalfoss, Low, and Molzahn 2010; Laidlaw et al. 2007). The ACT model is explicit that the six psychological processes that apply to those we term ‘clients’ also apply to the therapist. Our own discomfort may lead us to avoid important issues or moves with a client,

our own ‘stories’ about ageing may hook us in to behaving in ways that are not in the service of the client’s valued living. Such an explicit recognition is reflected in the high degree of experiential learning and participation encountered in good-quality ACT training and is designed to help therapists to hold their own age (and other group) stereotypes simply as mental events, acquired due to a particular history of cultural reinforcement. Such ‘ideas’ need not govern behaviour—providing one experiences these ideas *as ideas* flexibly, in a detached and open manner, and one commits to actions that are not consistent with ‘the story’.

Given this explicit focus on awareness of the psychological processes involved in treatment from both the patient and the therapist’s side of the interaction, it is reasonable to suggest that an ACT-based approach may also be a useful perspective to bring to clinical multidisciplinary teams, multi-agency working, and working with the systems in which older people live. These systems include healthcare systems, housing systems, and family systems. Such systems can unwittingly add to the burdens faced by older people in how the system responds to the behaviour and distress experienced by the older person. Systemic responses are highly influenced by the individual and collective appraisals that are made of the older person, their distress, and their behaviour. An ACT-based perspective may help a team or other system to hold such appraisals flexibly and to reduce their impact upon both clinical behaviour and practitioner well-being (Gauntlett-Gilbert 2011; Kangas and Shapiro 2011).

For instance, as multidisciplinary teams discuss a particularly challenging presentation of a client’s distress, it can be evident that ‘the story’ the team forms around this patient and their problems can then influence subsequent clinician behaviour. Words such as ‘frail’ or ‘fragile’ may make a team less likely to be active in setting activity goals. Stories that involve long histories of psychological difficulty also tend to make clinicians pessimistic about change and less likely to offer change-oriented therapies. Two important elements in ACT may be useful in such situations: first, it is likely that previous attempts at therapy may have been focused on

symptom reduction. ACT's focus on valued living in the presence of symptoms, thoughts, feelings, and so on is likely to be experienced as radically different by the patient and the team. Second, the explicit defusion of team members from their 'stories' about the patient may allow them to see the effect of 'the story' upon their clinical behaviour and therefore have greater choice over how they respond.

Similarities and Differences between ACT and Cognitive Therapy

There are substantial areas of overlap between ACT and cognitive therapy (CT), though also some notable differences. At the level of principle; both tend to be highly structured, involve a high degree of collaboration and participation from both client and therapist, involve goals often expressed in terms of here and now behaviours and aim to establish more reliable control over the things a person does—their behaviour. Furthermore, they share a focus on cognition and emotion as important factors that influence behaviour. Both ACT and CT allow for the person's learning history to have shaped their behaviour, their beliefs, and their moment-to-moment patterns of thinking and feeling. Both approaches focus more explicitly on disrupting maladaptive patterns of responding to historical events and their psychological sequelae *in the here and now*, rather than uncovering hidden or unconscious meanings that have their roots in experiences *there and then*. Both approaches allow therapists to focus on historical material in the service of current change strategies.

CBT is perhaps more explicit in using such historical work as a means to 'heal' (e.g. Janoff-Bulman 1992), reducing the power or emotion of traumatic memories and trauma-related beliefs. Cognitive therapists are also more likely to use direct cognitive-modification strategies as a means to emotion or behaviour change. ACT therapists, in contrast work with a less explicit focus on changing such private cognitive and emotional events, but seek to help an individual respond to them with greater choice and flexibility. Both approaches use 'exposure-based'

methods of treatment, though the function and purpose of exposure is thought of differently in these two approaches. In CBT (and in classical behaviour therapy), exposure is conceptualized as bringing someone into contact with a feared stimulus and preventing avoidance behaviour, such that extinction of fear occurs. In addition, emotional processing is thought to occur during prolonged exposure (Rachman 1980). From a cognitive therapy perspective, exposure also leads to changes in beliefs, such that the feared stimulus is reappraised as less threatening. In essence, exposure is engaged in to reduce fear and to change fear-related appraisals. In ACT, by contrast, exposure is seen as encouraging more flexible behaviour in the presence of a fear-eliciting stimulus. Whether or not fear diminishes or a person's appraisal of the stimulus changes is not considered to be especially relevant in an ACT conceptualization. Modelling, shaping, instigating, and reinforcing more flexible forms of behaviour in the presence of the feared stimulus are the goal. Interestingly, a recent empirical review by Craske et al. (2008) suggests that fear reduction during exposure does not predict therapy outcome.

Where ACT and CBT most diverge is in their concepts and their underpinning philosophical assumptions. CBT remains an approach that is specific to disorder. Indeed, significant scientific and clinical progress has been made when cognitive models of disorder allow more precise targeting of treatment, such as in the development of specific cognitive models of panic disorder (Clark 1986), obsessive compulsive disorder (Salkovskis 1985), and social phobia (Clark and Wells 1995). The specificity hypothesis suggests that specific cognitive distortions are implicated in specific conditions, and hence the more specific the model, the more targeted the treatment can be at the postulated mechanism of the disorder. By targeting the 'mechanism', the disorder will be treated, other symptoms of the disorder will reduce and the individual will function in more adaptive and healthy ways.

ACT, by contrast, has taken a trans-diagnostic approach to behavioural flexibility. The same functional technology has been shown to be useful across a wide range of problems by

focusing on the function of acts in context, rather than the form of psychological events. Second, the goal in ACT is not to ‘treat disorder’ in an eliminative manner, but to focus on promoting valued goal-directed behaviour in the presence of the symptoms, thoughts, and feelings that are typical of the ‘disorder’.

A further distinction is at the level of philosophical assumption. CBT takes an approach to the philosophy of science that could be described as ‘elemental realism’ (Hayes 2009). An elemental realist view of science could be described as typical of most science-based approaches in the natural sciences. In this view, the behaviour of the scientist is to ‘uncover’ the workings of the phenomenon that is being studied. They analyse the phenomenon into its parts, observe how the parts influence each other, and determine reliable, replicable patterns and predictions based upon these analyses. The success of their endeavour is reflected in the degree of match between theorized mechanisms and empirical observation, and the truth value of the scientist’s analysis is in how ‘accurately’ they are able to describe the workings of the phenomenon they are investigating. The applied scientist then uses this understanding of mechanism to intervene in the postulated causal mechanism, thereby bringing about change.

ACT has chosen a different path in the development of its treatment. Based on the philosophical position of pragmatism (James 1907), ACT has adopted a functional contextual approach to science (Hayes, Hayes, and Reece 1988). The scientist working from a functional contextual position seeks to understand the function of a whole act in a given context. It is the functions of that act within that context that govern the act, rather than the act being caused by or governed by specific aspects such as thoughts, urges, or drives. From this point of view, the scientist seeks to understand what features of the context (including things such as thoughts, feelings, history of responding in that context) are antecedent to and consequent upon a given behaviour (both overt behaviours and private events), and how these consequences are instrumental in shaping future responses to those antecedents in that context and other contexts.

For the functional contextual based scientist, their analysis of a phenomenon does not ‘uncover’ a truth about the universe. Functional contextualism is ‘aontological’. It makes no assumptions that there is a universe ‘out there’ to be uncovered. Instead, the functional contextual scientist specifies in advance the goals of their investigation, and the analysis is said to be ‘true’ to the degree to which it provides progress towards that scientific goal. This is known as the truth criterion of successful working or ‘workability’. The goal of contextual behavioural science (of which ACT is a part) has been stated as, ‘The prediction and influence of psychological events, with precision, scope and depth’ (Vilardaga, Hayes, and Levin 2009).

Such a way of talking about thoughts, feelings, and urges as ‘private behaviours’ is odd, given the ‘common sense’ way in which these things are dealt with in CBT. The value of the functional contextual approach is, however, that it keeps a clearer separation of what is a dependant variable and what is an independent variable, to use the terminology of science. This distinction is important, because the scientist needs to be able reliably to manipulate the independent variable and observe the effects on the dependent variables. From the functional contextual perspective, the only reliably manipulable independent variable is context: the antecedents and consequences surrounding an act, be that act overt or private, and the functional relationships these antecedents and consequences have upon the act.

Adapting ACT to the Specific Issues of Ageing

The central message of ACT (that attempts to control may be part of the problem, rather than the solution) is relatively counter-cultural. Many people struggle with the basic stance in ACT, due to our long histories of reinforcement by the ‘verbal community’ of controlling our expression of emotion, regulating our behaviour, and behaving in a consistent and rational manner. It is because of this difficulty that ACT gives emphasis to facing the struggle and closely examining the workability of control-based strategies. Older people are likely to be *no different* from

younger people in this regard. It is possible, however, that a longer history of investing in control-based strategies *may* make this shift in stance towards acceptance more difficult for some older people. Consistent with lifespan developmental thinking, older people experiencing many challenges and adversity over their lifespan develop an increased adaptive capacity to optimize function despite declining capacity (Heckhausen, Wrosch, and Schulz 2010). In this regard, the ACT philosophy of giving up control may resonate with an older person's experience, with the paradoxical outcome that giving up former means of engaging control may result in enhanced well-being and reduce discrepancy between a sense of achievement and false fixed beliefs about control.

Other ways in which ACT can be tailored to older people include ensuring that the metaphors and imagery techniques used in ACT are culturally accessible to this cohort. For instance, in one exercise (designed to increase experiential contact with values), clients are guided to visualize their own funeral and what they *would most wish* to be said about them and their lives in their eulogy (Hayes et al. 1999: 215). Petkus and Wetherell (2013) describe a case study in which this exercise is used successfully with a 69-year-old man. However, for some older people, this kind of imagery may already be well rehearsed in a relatively unhelpful way and it would then be easy for this exercise to have a variety of unintended consequences. Instead, therapists could focus on a shorter time scale: for example, imagining that through the therapeutic work some small but important changes begin to take place in how the client is living with their problems, imagining that it is their birthday in one year's time and that someone they care about is giving a speech about this previous year and how the person had been acting during that time.

Just as in some chronic health work, there may be activities that are no longer accessible to a client for reasons of physical ability or reduced independence. Therapists will need to explore with the client what values were being served by previously valued activities and try to

incorporate small steps in these directions, or creatively work out alternative ways to pursue those values.

Importantly, when considering how ACT should be tailored to older people, therapists should beware of falling into stereotypes about what older people can and cannot do, and what they will or will not relate to. In tailoring metaphors for adolescents, for instance, we might do a piece of values work around the metaphor of ‘if you got to choose the playlist that was your life, what “tracks” would you choose to have on it?’ Or an adaptation of the classic ‘Soldiers in the Parade’ exercise (Hayes et al. 1999: 158) can be to visualize thoughts as ‘Twitter feeds’ scrolling up the screen. While it might be the case that older people might find the playlist or Twitter feed metaphor harder to relate to, this should not be assumed! The key issue is that the function of a metaphor (contacting values, seeing thoughts as thoughts, etc.) is the important part, but that the content of the metaphor needs to be accessible to the specific client, in order that the intended function can operate. Age and cohort effects *may* be a factor that influences this accessibility, though there is likely to be as much intra-cohort variability as there is inter-cohort. Petkus and Wetherell (2013) give further ideas about adapting ACT to older people.

Evidence that ACT is Effective for Older People

As described above, the ACT literature is maturing, with one small pilot study of ACT vs CBT for generalized anxiety disorder in older adults reporting potentially positive results (Wetherell et al. 2011). Furthermore, McCracken and Jones (2012) show that intensive ACT for chronic pain has similar efficacy for people over the age of 60 as it does for younger people. Karlin et al. (2013) show that ACT treatment for depression in former combat veterans is effective, and that older veterans respond just as well as younger ones. Interestingly, older veterans were also less likely to drop out of therapy. In addition, there are some case studies describing the use of ACT for chronic pain in older people (e.g. Lunde and Nordus 2009). Butler and Ciarrochi (2007)

report a study of psychological acceptance and its relationship with quality of life in older people. As the ACT model predicts, psychological acceptance is associated with greater quality of life, particularly for those individuals whose productivity (hours spent in work, study, childcare, leisure time) was lower. Although cross-sectional, this study supports the concept that increasing psychological acceptance (particularly in those whose activity has been impaired due to age-related factors) should be a useful therapeutic target.

These early-stage investigations suggest that ACT is acceptable to older people, and the effects seen in these studies suggest ACT for older people is worthy of further investigation. This is in contrast to a relatively strong evidence base for cognitive-behavioural therapy (e.g. Laidlaw et al. 2008). Several of the existing controlled trials for ACT have, however, included people over the age of 65 (e.g. Gifford et al. 2004; Johnston et al. 2010; Twohig et al. 2010; Bohlmeijer et al. 2011; Butryn et al. 2011; Wetherell et al. 2011). These papers have not specified differential treatment response, acceptability, or attrition in relation to age. This is an encouraging sign, though specific applications of ACT for older people are needed to be fully confident of its usefulness with this cohort.

On a related note, a number of studies have investigated mindfulness or mindfulness-based cognitive therapy interventions with people over the age of 65 for a variety of conditions (e.g. dementia care-giving, Mackenzie and Poulin 2006; recurring depression, Smith, Graham, and Senthinathan 2007; chronic pain, Morone, Greco, and Weiner 2008, Wang and Feinstein 2011; emotional distress, Splevins, Smith, and Sampson 2009; and a particular type of cognitive deficit known as over-selectivity, McHugh, Simpson, and Reed 2010). These studies show that older people can develop mindfulness skills as well as younger people and can benefit from this intervention. This is another encouraging sign for the further investigation of ACT for older people.

A Strategy for the Development of ACT for Older People

Clearly the ACT model has the potential to be a credible and useful alternative method for intervening in the psychological issues often encountered in older age. There is some preliminary evidence supporting its utility; in addition, ACT could benefit from clinical development work targeted specifically at these issues. Practitioners in this area should be encouraged to use standardized outcome measures, as well as the growing number of useful process measures available, to track changes on ACT-relevant processes in response to interventions. Such a case-study approach can develop into single-case experimental designs, which not only help establish efficacy in cost-effective ways, but can also provide insight into mechanisms of treatment. Larger group-based designs are also needed. These often develop in a step-like manner with uncontrolled trials followed by randomized controlled trials.

Alongside such clinical development work, a programme of basic research is needed, investigating specific aspects of ageing and ACT concepts. For instance, how does ‘valuing’ change in later life? Are there age-related limits to cognitive defusion (or indeed, does age enhance defusion)? What adaptations are required to ACT in the presence of cognitive impairment? How does ageing affect the ‘story’ of oneself and one’s attachment to or liberation from self-limiting stories? There is a role to play for qualitative, experimental, and cross-sectional work using a variety of methods, as well as the clinical development work suggested. Finally, issues relating to the stress of caring for older relatives, particularly in the context of dementia, deserve careful attention from an ACT perspective (see *chapter oxfordhb-9780199663170-e-017* in this Handbook).

Summary

Whilst ageing is not inevitably a time of difficulty, the kinds of issue that can be problematic for people as they age (e.g. loss, cognitive problems, health issues, role transitions) can usefully be

considered from the perspective of ACT and CBT. Whilst there is a degree of overlap between these approaches at the level of technique, and even some shared concepts, they diverge more completely when we consider the conceptual and philosophical assumptions of each approach. There is growing evidence of the applicability and efficacy of acceptance-based approaches for older people's issues and a host of unanswered research questions in this area.

Given the global demographic transition, with an increase in the relative numbers of older people within societies and a welcome increase in longevity (United Nations Population Fund and HelpAge International 2012), people facing challenges associated with ageing, or those wishing to improve their well-being may come forward for psychological therapy. Behavioural scientists can be very useful to society by exploring this relatively less well-charted territory with increasing older populations, both clinically and scientifically. Our goal must be to continue to develop a range of alternative workable, practical solutions for problems and issues that will likely visit many of us and those we care about.

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Figure 1

The acceptance and commitment therapy model—processes of inflexibility and psychological flexibility

